MDR Tracking Number: M5-04-1899-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 2-26-04.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was the only issue** to be resolved. The functional capacity evaluation performed on 9/09/03 **was found** to be medically necessary. The work hardening program (initial and additional hours) from 8/18/03 through 9/29/03 **was not found** to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this Order. This Order is applicable to the functional capacity evaluation performed on 9/09/03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Decision and Order is hereby issued this 7th day of June 2004.

Regina L. Cleave
Medical Dispute Resolution Officer
Medical Review Division
RLC/rlc

NOTICE OF INDEPENDENT REVIEW DECISION

May 14, 2004

MDR Tracking #: M5-04-1899-01
IRO Certificate #: IRO4326

The ___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in Chiropractic Medicine. ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This 41 year old female sustained a work related injury on ___ when she slipped on a mango and fell forward. The documentation states her initial complaints were intermittent and sharp right knee pain, with a severity of pain of "3" on a scale from 1-10. She was also experiencing intermittent right leg pain, with a severity of pain of "2" on a scale from 1-10. On 07/16/03, the right knee and right leg x-rays were "unremarkable." On 07/21/03, the MRI report stated "chondromalacia patella changes of the medial femoral patella joint with mild intercapusular swelling." The treatment plan included physical therapy and work hardening program.

Requested Service(s)

Work hardening/conditioning – initial, work hardening/conditioning each additional hour and functional capacity evaluation from 08/18/03 through 09/29/03

Decision

It is determined that the work hardening/conditioning – initial, work hardening/conditioning each additional hour from 08/18/03 through 09/29/03 were denied. The functional capacity evaluations from 08/18/03 through 09/29/03 were approved.

Rationale/Basis for Decision

Admittance to a work hardening program includes a component of mental health. The medical records submitted did not adequately establish the medical necessity of the mental health treatment. Further, there is no documentation that established the patient's deconditioned status. Therefore, this patient did not properly qualify for work hardening.

When the work hardening was initiated, the patient was ___ status post injury. Therefore, insufficient time had elapsed to test the effectiveness of other therapeutic measures, such as therapeutic exercises at home and in the clinical setting, before establishing the need for a formalized, high level of service. Rather, best practices in medicine and the standard of care should have been to explore other options first, and then if necessary, evaluate the patient for entry into such as aggressive program.

Review of work hardening program daily notes revealed that on all but two occasions during the entire 6 weeks, the patient's pain level remained unchanged with the therapy ("no change with treatment"). Work hardening programs require daily treatment and patient response to treatment be documented and reviewed to "ensure continued progress. " According to the records, this required progress did not occur.

Therefore, the work hardening/conditioning – initial, work hardening/conditioning each additional hour from 08/18/03 through 09/29/03 were denied. The functional capacity evaluations from 08/18/03 through 09/29/03 were approved.

Sincerely,